KEMMET DENTAL DESIGN

1015 S Broadway Suite 24

Patient Information

Today's Date_____ How did you hear about us?_____

Patient Name_____Preferred Name_____

(First) (Last) (MI)

Address_____City_____State_____Zip_____

Phone Number _____ _____ _____

(Home) (Cell) (Work)

Email Address_____SSN_____

May we contact you though Email and/or Text Messages to remind you of future appointments? Y/N

Birth Date_____ Gender: M/F Marital Status_____

Spouse's Name_____

Primary Care Physician_____

Dental Information

Reason for today's Visit_____

Do you have any questions or concerns for the doctor?_____

How would you rate your Smile? (Circle one) Excellent Good Fair Poor Isn't a Concern for me

How often do you Brush?_____ Do you Floss? Y/N How often?_____

X_____Date_____

(Signature of Patient or Guardian if Minor)

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Financial Agreements

As a courtesy, Kemmet Dental Design will bill my insurance company on my behalf. I am responsible for any portion of my treatment not covered or paid by my insurance company. If I do not currently have dental benefits, I agree to pay the full amount due for all completed services prior to or on the day of my appointment. Any account that has not been settled within 60 days from the date of service will be subject to an annual service fee of 18.5%. Any missed monthly payments will be subject to a non-payment fee of $35. I understand that I will be responsible for all court costs, collection fees, and attorney fees in the event of non-payment. If my account is sent to collections or I demonstrate consistently poor pattern of payment, I understand that I may be dismissed as a patient.

Kemmet Dental Design values you as a patient and as such, we reserve your appointments in advance. We ask that you give at least 48 hours notice for any appointment that you are unable to keep. If you show a consistent pattern in cancelling under 48 hours or not showing up for scheduled appointments, all future appointments will only be scheduled by paying a refundable reservation fee of $100/hour for any appointment. This reservation fee is non-refundable if the appointment is cancelled within 48 hours or you fail to show for your scheduled appointment. Furthermore, if you exhibit a pattern of consistency, such as two failed appointments in 6 months, you may be dismissed as a patient in our practice.

X_____Date_____

(Signature of Patient or Guardian if Minor)

Dental Insurance

Policy Holder_____Relationship to Patient_____

Employer_____

Insurance Company_____SSN and DOB of Policy Holder_____

Insurance Company Address _____

Insurance Phone Number_____ID#_____Group #_____

I authorize Kemmet Dental Design to release information as needed to my insurance company, including but not limited to: diagnosis, records of treatment provided or any examination received. I authorize my insurance company to pay out my dental benefits directly to Kemmet Dental Design. I understand that dental insurance is a contract between myself and my insurance company and that any lapse in insurance coverage will result in sole responsibility and full payment of dental services rendered. I understand that my insurance benefits may pay less than the actual charge for services. I acknowledge that I am responsible for any portion of treatment not covered by my insurance company for myself and/or my dependants.

X_____Date_____

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General Dentistry Informed Consent

1. **Examination and X-rays:** I understand that my initial visit may require radiographs in order to complete my examination, diagnosis and treatment plan.
2. **Changes in Treatment Plan**: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on my teeth, that were not discovered during my examination, the most common being root canal therapy following routine procedures. I give my permission to Dr. Kemmet to make any changes or additions necessary.
3. **Temporomandibular Joint Dysfunctions (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower subsequent to routine dental treatment wherein the mouth is held in an open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist, and the cost of which is my responsibility.
4. **Fillings:** I understand that care must be exercised in chewing on my filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling
5. **Removal of Teeth:** An Alternative to removal has been explained to me (root canal therapy, crowns, periodontal treatment, etc.) and I authorize either Dr. Kemmet or Dr. Laurence to remove the following teeth and any others necessary for the reasons in paragraph 2. I understand that removing teeth does not always remove all infection present and it may be necessary to receive further treatment. I understand the risks involved in having teeth removed, some of which are, pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time, or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
6. **Crowns, Bridges, Veneers, and Bonding:** I understand that sometimes it is not possible to have an exact match for the color of my natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns, which my come off easily and that I must be careful to ensure that they are kept on until the permanent crowns can be delivered. I realize that the final opportunity to make final changes in my crowns, bridges or cap(including shape, fit and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures affect my tooth surfaces and may require modification of daily cleaning procedures.
7. **Dentures Complete or Partial:** I realize that the full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including, looseness, soreness and the possibility of breakage. I realize that the final opportunity to make changes in my denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

8. **Endodontic Treatment(Root Canal):** I realize there is no guarantee that Root Canal Therapy will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal therapy (apoicoetomy).
9. **Periodontal Treatment:** I understand that I have a serious condition causing gum inflammation and/or bone loss and that can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products, and follow other recommendations.

Consent: *I understand that dentistry is not an exact science, therefore: reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment.*

X_____Date_____

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Notice of Privacy of Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights as a privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is available for me to read. I understand that Kemmet Dental Design has the right to change its Notice of Privacy of Practices from time to time and that I may contact Kemmet Dental Design at any time at the above address to obtain a copy of a current Notice of Privacy Practices. Any uses or disclosures not included in this form will be made only with my written permission.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, health operations or payment. I also understand that you are not required to agree to these requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X_____Date_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION

(This includes appointment confirmation, financial and treatment options.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I may revoke my authorization at any time, as long as it is done in writing

Office Use Only!!!!!

As administrative representative at Kemmet Dental Design, I attempted to obtain the patient's (or representatives) signature on the Acknowledgement but did not because:

- o I could not communicate with the patient
- o The patient refused to sign
- o The patient was unable to sign because_____
- o Other_____